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Los Angeles County Health Agency Strategic Priorities
September 29, 2015

Consumer Access to and Experience with Clinical Services

Strategic Priority: Streamline access and enhance customer experience for those who need services from more than one Department, including by promoting information-sharing, registration, care management, and referral processes, training staff on cross-discipline practice, and increasing co-location of services.

Goal 1: Implement staff workflow processes and technical infrastructure necessary to ensure clients can access services in another Department without having to duplicate registration, financial screening, and eligibility/determination processes; where prudent, align Departments' financial policies governing eligibility and payment for services from self-pay individuals.

Goal 2: Develop joint care management plans for individuals served by more than one Department.

Goal 3: Implement Agency-wide referral processes and technical infrastructure and train staff on protocols through which clients can be identified and referred directly to services in or funded by another Department.

Goal 4: Expand number of directly-operated and contracted clinical sites at which individuals can receive co-located physical, mental, substance use, and public health services; train staff to effectively work within co-located sites.

Goal 5: Successfully implement DHS' Electronic Health Record (EHR) "ORCHID" at all DPH sites that deliver health care services suitable for ORCHID implementation.

Goal 6: Determine best short- and long-term course of action with respect to the secure sharing of personal health information, in a manner consistent with all applicable state/federal privacy and security regulations, on clients shared between DMH and DHS/DPH, including consideration of a Cerner Hub approach vs. potential shift to a single EHR with appropriate interfaces to contracted partners as needed to ensure efficient billing mechanisms.

Proposed outcome metrics:

- Number of DPH sites that have completed ORCHID implementation
- Board-approval of short- and long-term method for sharing clinical information between DMH and DHS/DPH
- Adoption of common registration, financial screening, and eligibility processes
- Increased number of staff cross-trained to properly identify and manage and/or refer individuals needing care within another domain
- Increased number of referrals between Departments that are appropriately dispositioned using a streamlined referral process; wait time to access services/programs post-referral
- Increased number of individuals with care plans incorporating more than one system
- Increased number of staff trained on effective care management practices within co-located clinical sites
- Increased number of individuals provided with multi-departmental services (directly operated and as contracted via the County) within co-located sites
- Enhanced customer experience as measured by surveys or other standard tools

Major organizational next steps:

- Map scheduling, registration, financial clearance/screening, and referral processes in each Department; convene a work group from the three Departments to determine how best to harmonize differences.
- Convene Health Agency IT Leadership Council comprised of technical and business leadership from each Department to ensure IT-related strategy and decisions made within each Department balance Agency-wide and Department-specific interests.
- Hire external consultant to perform a detailed, objective assessment of the best way to share information across the three Departments, understanding the needs of community partners and the complexity of financial/billing functions and responsibilities, including consideration of a health information exchange, interfacing existing applications, and implementation of an enterprise, single EHR for clinical functions.
- Convene a Health IT Task Force, including representation from DHS, DMH, DPH, Probation, Sheriff, CIO, and CEO, to assist consultants in the above evaluation, providing open access to their specific Department's resources and IT infrastructure, to ensure the outcome of the consultant's report outlines clear recommendations, to be delivered to the Board of Supervisors (BOS), regarding best short-and long-term strategy with respect to sharing/accessing clinical information; other County Departments (e.g., DCFS) should be consulted and involved as needed.
- Assess availability of space at all directly-operated clinical sites, including potential for space swaps.
- Evaluate and, where appropriate, develop mechanisms to align existing processes for obtaining input from clients/consumers/patients on service/program quality and customer experience, (e.g., surveys, complaints and grievances).

Housing and Supportive Services for Homeless Consumers

Strategic Priority: Develop a consistent method for identifying and engaging homeless clients, and those at risk for homelessness, across the three Departments, linking them with integrated health services, housing them, and providing ongoing community and other supports required for recovery.

Goal 1: Evaluate and reconfigure, as needed, housing and homeless services within the Agency and Departments to facilitate improved outcomes for homeless clients, including but not limited to the reduction/elimination of eligibility barriers and greater sharing of Departmental resources, to ensure that resources are available to homeless clients regardless of where they present.

Goal 2: Develop an accurate way to identify homeless clients, and those at risk of homelessness, currently served across the three Departments (e.g., development of a real-time unduplicated database, flag within shared client record) for the purpose of identifying priority clients who are determined to be likely to benefit from services from multiple Departments to regain health and residential stability.

Goal 3: Develop and implement shared standards and practices for ensuring a full range of housing, health, and prevention services are able to be delivered to clients based on client-specific needs.

Goal 4: Improve and expand upon multidisciplinary street engagement teams capable of effectively engaging homeless people living outdoors throughout the County with the express goal of securing interim and permanent housing.

Goal 5: Develop and open a range of "bridge" residential services that provide low-barrier, welcoming programs (e.g., sobering centers; day centers with showers, meals, and health services; recuperative care; detox centers; stabilization housing; congregate supervised living; and other effective bridges to permanent housing) for homeless individuals with complex health conditions in high density neighborhoods (e.g., Skid Row, Hollywood, Venice) and in unincorporated areas of LA County.

Goal 6: Maintain a real-time inventory of available residential slots, funded and usable by all three Departments, that facilitate immediate placement of homeless clients into available interim and permanent residential options appropriately matched to various need indicators (e.g., accessibility, level of on-site services, neighborhood, age).

Goal 7: Obtain Medi-Cal coverage, when possible, and successfully link individuals, where clinically appropriate, to comprehensive, integrated health services that are delivered in a way that is tailored for the unique needs of homeless individuals.

Goal 8: Develop screening questions for those conditions that lead to homelessness that could be incorporated into the practices of all three Departments along with methods and plans to link individuals to needed supports and services as part of the delivery of health care, mental health and public health services.

Goal 9: Engage in policy development and technical assistance activities to enhance the availability of high-quality, affordable, stable housing stock within LA County.

Proposed outcome metrics:

- Increased number of families at risk for homelessness that are provided support services to prevent homelessness

- Decreased number of emergency department visits and ambulance transports of homeless individuals for non-emergency services
- Decreased rate of incarceration for non-violent offenses related to being homeless
- Increased number of homeless individuals newly placed in Permanent Supportive Housing (PSH), including breakdown by geography (e.g., Skid Row, unincorporated areas)
- Increased percent of individuals housed by the Departments who remain housed two years after initial placement
- Increased number of individuals incarcerated in LA County jails who are housed upon community re-entry (among those who otherwise would have been homeless upon release)
- Increased number of homeless clients able to be placed in interim or permanent housing on the same day they have been identified as willing to move into housing and/or receive services
- Among homeless individuals assigned to a DHS or community partner medical home, increased number with at least one primary care visit in the past 12 months
- Increased number of homeless individuals who are linked to physical, mental, and/or substance use services
- Increased number of homeless individuals assisted via street outreach efforts in areas of the County experiencing high concentrations of people living outdoors

Major organizational next steps:

- Analyze housing/homeless-specific services and current program eligibility criteria in each Department to determine what level of further integration/consolidation would be useful toward achieving improved outcomes for homeless people, how these efforts interact with non-health related efforts, how eligibility criteria can be aligned Agency-wide, and any areas of additional funding needed to expand services.
- Explore with IT and other appropriate parties the most effective way to develop and maintain a real-time database/log of shared clients who are homeless.
- In partnership with other County Departments and non-County community partners, develop a priority list of types of residential programs that are most in need and develop a specific timeline for bringing them online.
- Work closely with CEO Homeless initiative coordinator to ensure other County departments (e.g., Sheriff, Probation, CDC, Fire, DPSS, DCFS) are working together to build a County-wide service system for homeless individuals.
- Work with DPSS and Community and Senior Services to create necessary program linkages and supports.

Overcrowding of Emergency Departments by Individuals in Psychiatric Crisis

Strategic Priority: Reduce overcrowding of County Psychiatric Emergency Services (PES) and private hospital Emergency Departments (EDs) by children and adults in psychiatric crisis.

Goal 1: Increase alternatives to PESs and private EDs across all regions of LA County by establishing additional psychiatric urgent care centers and crisis residential services, augmenting the spectrum of lower levels of care to include psychiatric recuperative care and additional crisis stabilization capacity, expanding access to structured outpatient services accessible to those at/before a time of crisis, and fully implementing the Alcohol and Drug Medicaid benefit.

Goal 2: Improve the utilization of inpatient services by ensuring that individuals who can be managed in a less restrictive setting are dispositioned appropriately and that those who are admitted to inpatient units are discharged as soon as clinically appropriate.

Goal 3: Maximize federal funds available for the purchase of services or placements to support care to individuals in or recently in crisis.

Goal 4: Assess and redesign existing processes to improve audits of IMD utilization in order to reduce length of stay and thus reduce wait times for those in public and private inpatient psychiatric units.

Goal 5: Ensure law enforcement and community-based mental health assessment teams are adequately trained on the wide array of outpatient service, programmatic (e.g., case management) and placement options available to individuals in psychiatric crisis.

Goal 6: Evaluate options to increase the stock of private psychiatric inpatient beds (e.g., increasing rates, developing mechanisms to take advantage of changes in the IMD exclusion).

Proposed outcome metrics:

- Decreased average morning census of children and adults on involuntary holds in County PESs and private EDs
- Decreased administrative days as a percent of inpatient psychiatric days in public and private hospitals
- Increased number of visits to urgent care centers by individuals on involuntary holds and ultimate disposition type (e.g., home, PES/ED, inpatient admission, community-based placement)
- Decreased average length of stay in public and private EDs by those on involuntary psychiatric holds
- Increased number of new urgent care centers opened
- Increased number of individuals in psychiatric crisis in public and private EDs who are discharged to non-locked settings with medication and outpatient follow-up plans
- Increased number of alcohol and drug residential and detox service placements/slots available
- Increased number of crisis residential beds available
- Recidivism rate among those visiting County PESs (and private EDs to the extent data is available)

Major organizational next steps:

- Assess current and anticipated future financial allocations from each Department toward individuals in psychiatric crisis, especially those on involuntary holds, so that resources can be maximally aligned toward services and placements most capable of responding to the needs of the target population.
- Assess and align, where indicated, DHS, DMH, and DPH clinical, programmatic, and housing services to create novel placements for individuals who could be diverted from EDs or inpatient units.

- Open additional 24/7 LPS-designated psychiatric urgent care centers, including at sites near Olive View-UCLA Medical Center, in the Antelope Valley, in the Long Beach area, in the East San Gabriel Valley, and in association with Harbor-UCLA Medical Center.
- Assess utilization of inpatient psychiatric units and IMDs to identify opportunities to improve flow.

Access to Culturally and Linguistically Competent Programs and Services

Strategic Priority: Ensure access to culturally competent and linguistically appropriate services and programs as a means of improving service quality, enhancing customer experience, and helping to reduce health disparities.

Goal 1: Implement mechanism to systematically collect and analyze Race, Ethnicity and Language (REAL) data and data for other culturally relevant factors (e.g., LGBTQ, physical disability) among consumers; use data to identify and report relevant health-related disparities and inform ongoing program design.

Goal 2: Systematically survey and publicly report client satisfaction with Department activities and services from a cultural perspective.

Goal 3: Design, establish, and implement core competencies for new employees and regularly train existing County workforce on providing culturally relevant care and customer service, including attention to the needs of specific race/ethnic groups, the disabled, veterans, LGBTQ, immigrant/refugees, the elderly, and other vulnerable groups within local communities.

Goal 4: Ensure clinical sites are able to provide real-time professional interpreter/translation services when required or requested by the client through building both in-person and technology-based (e.g., telephone, video-conferencing) resources; ensure clients are proactively made aware of their right to receive and the availability of such services.

Goal 5: Ensure clinical sites have signage and written client materials available in the preferred primary languages of their local communities.

Goal 6: Share and coordinate existing culturally appropriate efforts and staffing models across Departments that have been proven effective in reducing disparities, enhancing care coordination, and increasing community awareness of health issues and that have demonstrated positive health outcomes.

Proposed outcome metrics:

- Disparities according to REAL and other relevant cohorts
- Results from clients/consumers/patients surveys
- Evaluation of impact and effectiveness of training programs related to cultural competency; number of individuals who have completed training
- Percent of total clinical sites that can provide real-time access to translation/interpreter services
- Percent of sites that have completed self-assessments and enhancements of signage and written materials that met the cultural and linguistic needs of communities served

Major organizational next steps:

- Convene and/or evaluate existing Department-, program-, and/or facility-level cultural competency committees, comprised of consumers, their families, and front-line staff, to provide input on how to continually enhance cultural competency of existing programs.
- Perform cultural competency assessment of directly-operated and contracted sites using an externally validated tool appropriate to the size and diversity of the County.
- Create mechanism to formally survey clients/consumers/patients on cultural competency of services and programmatic offerings.
- Engage organized labor on ways to formally enhance delivery of culturally competent care/services.

- Conduct inventory of currently available translation/interpreter resources/infrastructure, signage, and written client materials within clinical sites.
- Assess the ability of specific programs/facilities to care for special populations (e.g., use of peers/those with lived experience, family involvement) and take advantage of the strengths of each Department.

Diversion of Corrections-Involved Individuals to Community-Based Programs and Services

Strategic Priority: Successfully divert corrections-involved persons with mental illness and addiction who may otherwise have spent time in County jail or State prison by placing them into structured, comprehensive, health programming and permanent housing, as tailored to the individual's unique situation and needs.

Goal 1: Establish the Office of Diversion and Re-entry with the capability to coordinate diversion efforts across Departments, create placements appropriate for the wide array of individuals who might be diverted and develop programs that support the recovery and improved health of these diverted individuals. The Office will provide contracting, technical and evaluation support, and expansion of current evidence-based diversion programs run by DHS, DMH, and DPH necessary for a successful County-wide intervention.

Goal 2: Establish placement opportunities and comprehensive health programs (i.e., physical health, mental health, public health, and substance use case management and clinical services) to address the needs of individuals deemed eligible for diversion.

Goal 3: Work with Court 95 and the LA County District Attorney's Office to establish sufficient community placements to meet the relevant demand among Misdemeanants Incompetent to Stand Trial (MIST) deemed eligible by law enforcement for diversion.

Goal 4: Build the necessary administrative infrastructure necessary to rapidly place potential diversion candidates into housing (e.g., possible creation of a Diversion Connection Access line with extended hour capabilities).

Goal 5: Develop diversion education and awareness campaign to heighten awareness of diversion opportunities and programs among County courts, prosecuting and defense attorneys, law enforcement and custody staff as well as mental health, substance use, and other relevant clinical staff.

Proposed outcome metrics:

- Increased number of individuals diverted from jail, by intercept and offender category (e.g., MIST)
- Percent of diverted individuals who successfully complete diversion plan
- Percent of diverted individuals who have not re-offended within one year following completion of their diversion plan
- Average time spent in custody after diversion plan is approved
- Increased number of diversion programs and housing units available to diversion clients
- Increased number of cases where diversion programs are the recommendation of the Courts

Major organizational next steps:

- Establish the organizational structure and key leadership positions within the Office of Diversion and Re-entry.
- Hire an Office Director and team with a sufficient leadership structure to interface with the courts and custody as well as develop and identify providers for required housing, placements, and programming.
- Build multi-department diversion stakeholder group to guide Office priorities.
- Continue to build relationship with District Attorney's ongoing diversion effort.
- Determine how DMH and Substance Abuse Prevention and Control (SAPC) programs and resources interact with and support a broad County diversion program.
- Align program metrics across each Department's current diversion programs.

Implementation of the Expanded Substance Use Disorder Benefit

Strategic priority: Maximize opportunities available under the recently approved Drug Medi-Cal waiver to integrate Substance Use Disorder (SUD) treatment services for both adults and youth into LA County's mental and physical health care delivery system.

Goal 1: Transition homeless and criminal justice-involved individuals receiving SUD residential treatment into appropriate Department housing programs as part of the SUD continuum of care.

Goal 2: Develop knowledge and skills of clinical staff in Departments' directly-operated and contracted primary and specialty care facilities on the American Society of Addiction Medicine's (ASAM) levels of care based on medical necessity, including the interaction of SUDs with physical health and mental health conditions, and how to appropriately screen and link individuals with SUDs into appropriate levels of care.

Goal 3: Advocate with the State Legislature and the Department of Health Care Services (DHCS) to place all drug treatment medications approved by the federal Food and Drug Administration (FDA) on the Drug Medi-Cal (DMC) formulary; expand the use of these medications by both mental and physical health practitioners within LA County's health care delivery system.

Goal 4: Increase the number of Departments' directly-operated and contracted providers that are DMC-certified.

Goal 5: Implement SUD Screening, Brief Intervention and Referral to Treatment (SBIRT) protocol in Departments' directly-operated and contracted clinics and programs.

Proposed outcome metrics:

- Increased number of eligible homeless and criminal justice-involved individuals referred to DHS and DMH housing programs upon completion of their SUD treatment
- Increased number of SUD homeless and criminal justice-involved patients with co-occurring SUD mental health and/or physical health conditions housed in DHS and DMH programs
- Increased number of clinical personnel in directly-operated and contracted County clinics trained to accurately identify SUDs, provide Medical Assisted Therapy (MAT), and make referrals for SUD treatment based on medical necessity as determined by ASAM criteria
- Addition, by California DHCS, of all FDA-approved addiction treatment medications to the DMC formulary without a TAR requirement
- Increased number of Departments' directly-operated and contracted facilities that are DMC certified
- Increased number of Departments' directly-operated and contracted clinical personnel trained in SBIRT
- Increased percentage of Departments' clients in directly-operated and contracted clinics receiving an annual screening for substance use in the past year

Major organizational next steps:

- Prepare and submit the DMC Organized Delivery System (ODS) implementation plan required under the 1115 Waiver's DMC ODS Special Terms and Conditions to obtain BOS approval to opt into the Waiver.
- Upon BOS approval, submit the DMC ODS implementation plan to DHCS and Centers Medicaid and Medicare (CMS) for approval as required under the STCs.
- Establish workgroups comprised of DHS, DMH, DPH, other County departments, and key external stakeholders to execute the DMC ODS Waiver implementation plan once approved by DHCS and CMS.

- Provide technical assistance, training and infrastructure investments for the three Departments and their provider networks to build administrative, clinical, and workforce capabilities and capacity to meet the increased demand for SUD services under the DMC ODS Waiver.

Vulnerable Children and Transitional Age Youth

Strategic Priority: Improve the County's ability to link vulnerable children, including those currently in foster care, and Transitional Age Youth (TAY) to comprehensive health services (i.e., physical health, mental health, public health, and SUD services).

Goal 1: Develop comprehensive individualized treatment plans, including temporary and permanent placements able to provide integrated mental health, substance use, and physical health services, for children in foster care that are "difficult-to-place" due to health-related issues.

Goal 2: Develop and implement new approaches to community outreach and engagement to high-risk children/youth and TAY (e.g., those with HIV/STDs, homeless youth, LGBTQ, unaccompanied minors).

Goal 3: Continue to develop and evolve a comprehensive health services package (i.e., physical health, mental health, substance use, public health) available to Commercially Sexually Exploited Children (CSEC) in LA County.

Goal 4: Develop a package of comprehensive aftercare services, including mechanisms for appropriate referral and linkage available immediately upon release, for youth in Probation Camps and Juvenile Halls and TAYs in the adult corrections system.

Goal 5: Create or adopt an externally available mobile tracking and communication tool usable by TAY to help them gain access to educational and service information.

Proposed outcome metrics:

- Increased percent of "difficult-to-place" youth in DCFS system that are successfully linked with comprehensive treatment services and receive timely, appropriate residential placement in a home-like setting where feasible
- Decreased number of children/youth with physical and/or mental health challenges who experience placement disruptions
- Increased number of high-risk TAY newly linked to and receiving mental health and/or SUD services
- Increased number of CSEC youth using services from an agency Department
- Increased number of youth and TAY leaving the correctional system with an aftercare plan addressing mental health, substance use, and/or physical health needs
- Increased number of youth/TAY with full implementation of their aftercare plan
- Increased number of TAY who use an electronic tool to "stay in touch" with service providers, DCFS social workers, Probation officers or other parts of their community

Major organizational next steps:

- Establish a working partnership between the Agency, the County's Office of Child Protection, relevant County Departments (e.g., DCFS, Probation), and community-based entities (e.g., school districts).
- Evaluate current models of integrated treatment teams (e.g., Child and Family Teams implemented by DCFS and DMH) and determine their applicability and potential scalability for improving management of target populations.
- In partnership with DCFS, clearly define "difficult to place" youth appropriate for Goal 1 interventions.
- Convene workgroup, involving entities outside the Agency as needed, to develop a mechanism (e.g., utilize a common data collection system) to ensure that all Department programs that may interact with CSEC have a way to identify individuals and employ consistent methods to capture relevant information.

- Convene an agency-level CSEC workgroup to enhance Department collaboration on health-related issues; participate in County-wide CSEC workgroups as appropriate.
- Identify funding to create and/or implement the mobile tracking and communication tool.

Chronic Disease and Injury Prevention

Strategic Priority: Align and integrate population health with personal health strategies by creating healthy community environments and strengthening linkages between community resources and clinical services.

Goal 1: Expand access to chronic disease prevention programs (e.g., National Diabetes Prevention Program (NDPP)) for priority populations.

Goal 2: Scale and spread the use of team-based care approaches in Los Angeles (e.g., Community Health Worker (CHW), pharmacist-led Medication Therapy Management (MTM) programs) for persons with chronic health conditions.

Goal 3: Expand access to evidence-based tobacco cessation treatment for priority populations.

Goal 4: Reduce youth violence through strategies targeted at the community-level and broader social determinants of health. Example tactics to be pursued include building on the Parks After Dark (PAD) model to expand gang intervention and safe passage programs, integrating DHS, DMH and DPH services and outreach into community-based youth violence efforts, and promoting a school climate that ensures adequate access to high-quality and coordinated social, medical, and behavioral health services for students and families (e.g., a coordinated school health model).

Goal 5: Encourage and assist high-risk populations (e.g., those prescribed atypical anti-psychotics) to engage in exercise and movement and to access healthy food/nutrition options.

Proposed outcome metrics:

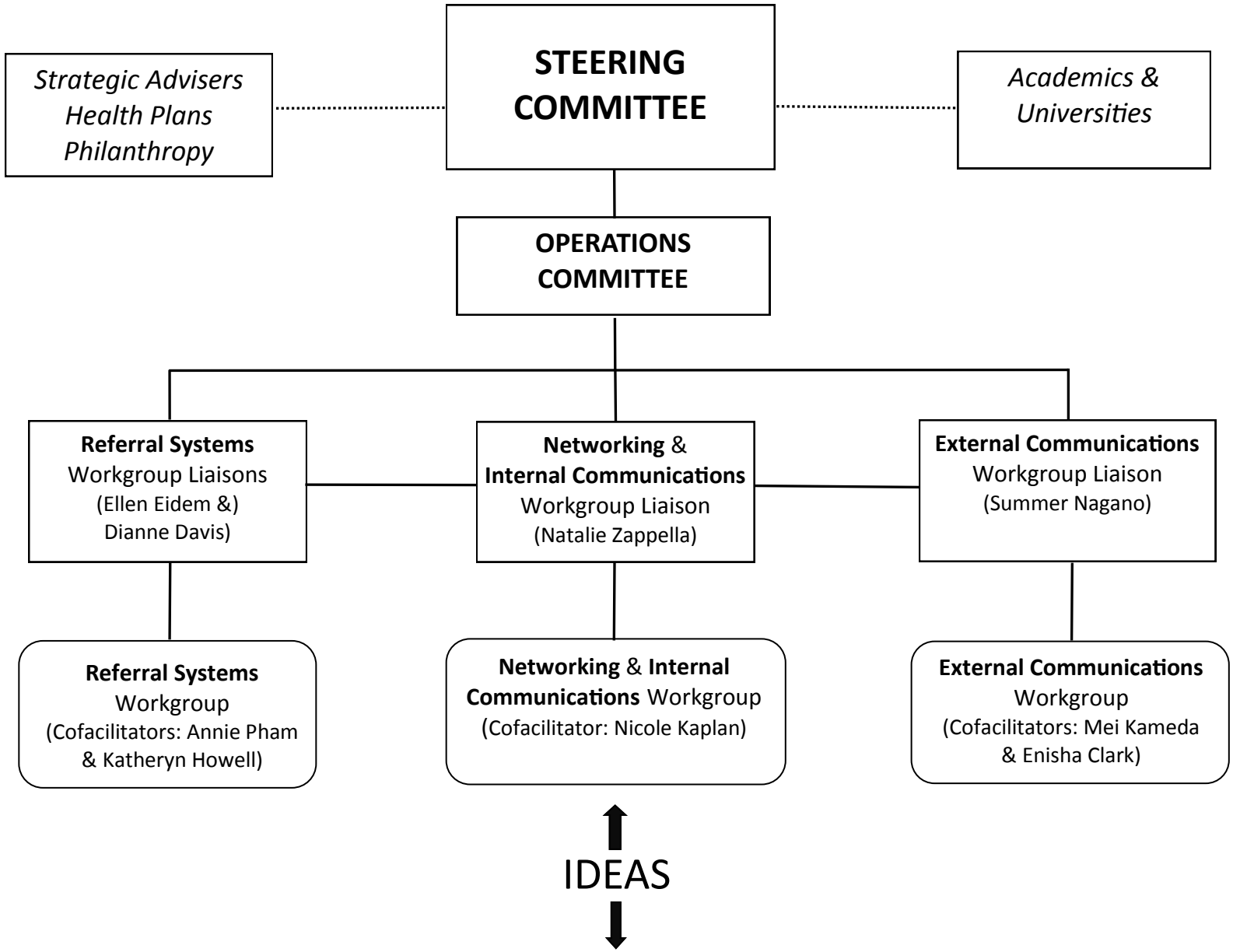
- Increased number of at-risk persons enrolled in chronic disease prevention programs (e.g., NDPP)
- Increased number of at-risk persons with well-controlled chronic conditions (e.g., heart failure, diabetes, hypertension)
- Increased number and level of satisfaction of clients reached with CHW and MTM programs
- Increased number of healthcare providers trained in the provision of evidence-based tobacco treatment interventions
- Decreased prevalence of tobacco use among adult LA County residents
- Increased number of schools with wellness policies that adopt and integrate elements of a coordinated school health model
- Increased number of PAD parks in communities with high rates of violence that include co-located social, physical, behavioral, and public health services
- Decreased number of serious and violent crimes and gang-related crimes in PAD park communities relatives to comparison sites
- Decreased number of trauma-related ED visits and hospitalizations

Major organizational next steps:

- Develop assessment tools/methods for collecting needed baseline and ongoing performance/progress data for above initiatives.
- Perform baseline inventory and assessment of existing CDC-recognized NDPP providers in Los Angeles; develop and implement outreach and provider engagement strategy to promote and support broader provider participation.

- Perform baseline inventory and assessment of select existing team-based care models (e.g., community pharmacies screening programs, MTM programs); develop and provide technical assistance to agencies and providers interested in expanding participation.
- Establish standards of care for the delivery of evidence-based tobacco interventions; revise or update standards to address the assessment and treatment of tobacco dependence.
- Develop necessary education objectives, curricula, evaluation tools, and training schedules to enhance tobacco cessation efforts; train providers to deliver evidence-based tobacco cessation treatment.
- Analyze trauma-related data to better tailor and target prevention interventions.
- Conduct baseline inventory and assessment of existing violence prevention, social service, health and behavioral health resources in PAD park communities with a goal to develop a cross-referral system; convene key partners to develop and implement targeted strategies to facilitate referrals and coordination between organizations, provide technical assistance, and evaluate impact of initiatives.
- Analyze available data and assess impact of current programs targeted at social determinants of youth violence (e.g., diversion programs, Teen Court programs) to understand gaps and priority opportunities for future intervention.

Structure of the Los Angeles Alliance for Community Health and Aging



September 2015
Vol. 1, No. 1

LAACHA Update

Newsletter for members of the Los Angeles Alliance for Community Health & Aging

Welcome to the premiere issue of LAACHA Update!

We are excited to launch this new communications tool to keep LAACHA members informed about what is happening with our LAACHA family. Our goal is to publish at least quarterly, after our General Meetings and include a meeting summary.

As this newsletter evolves, please let us know if there is other information you would like to see included. We welcome your comments, ideas, and contributions!

Save the Date

The next LAACHA General Meeting is scheduled for **Monday, January 25, 2016, 1 pm - 4 pm.**

Mission of LAACHA

Increase accessibility and reach of evidence-based health promotion programs for at-risk, marginalized, older adult residents, caregivers, and families in Los Angeles City and County through collaboration among community organizations and health systems.

General Meeting Highlights

More than 40 LAACHA members attended the last General Membership meeting on June 4 in downtown Los Angeles. Many items were on the agenda for this 3-hour meeting, including a reintroduction of LAACHA, discussions on changes in health care design and Evidence-Based Programs (EBPs) at the state and local levels. Workgroups had time to meet, then came back and shared their workgroup's progress with the rest of the attendees.

In addition, LAACHA members from three community-based organizations, participated in a panel discussion, titled "Agencies Share EBP Experience." The panelists were **Nicole Kaplan**, Motion Picture and Television Fund (MPTF); **Kimberley Woods**, Episcopal Communities & Services/Community Housing Management Services (Episcopal/CHMS); and **John Kotick**, St. Barnabas Senior Services (SBSS).

Nicole said that in 2006, MPTF conducted a survey of adults aged 60+ years in the entertainment community. Many of them reported they were isolated and not as involved in community activities as they would like to be. A decision was made to offer the programs *Healthy Moves* (done in the home) and *Healthier Living*. Training was provided by Partners in Care Foundation (PICF) and Kaiser Permanente, with MPTF operating these classes under licenses from these organizations. MPTF funds its EBP programs through its general budget. The fee for the classes is $50, but MPTF provides scholarships for those who need financial assistance.

Kimberley shared that Episcopal/CHMS offers a care program called Creative Living Plus, which is run like a family. When the agency realized that its residents had unmet needs, it conducted an extensive survey to find out what these needs were. The agency was fortunate to have an EBP champion in LAACHA member **Phyllis Willis**, who trained many of its staff. A vast array of EBPs are offered, including *Chronic Disease Self-Management Program* (CDSMP), *Diabetes Self-Management Program*, *A Matter of Balance,* and *UCLA Memory Training.* Staff members assist the residents with aging in place. Funding for these programs is derived from the agency's foundation.

According to John, SBSS provides a variety of services for older adults that promote healthy aging. Most of its clients are about 70 years old and are low income, averaging $900 per month. SBSS wanted to provide an additional dimension of services, which would assist their clients in maintaining health. Its roster of EBPs include *CDSMP, Walk with Ease, UCLA Memory Training*, and *A Matter of Balance.*

Did You Know…

> The latest LAACHA Roster has been emailed to all LAACHA members. If you missed the September issue, please contact Denise Pacheco at dpacheco@ph.lacounty.gov. The roster will be updated and emailed quarterly.

> The Stanford CDSMP curriculum is now available in Hmong. The 2012 manuals are available in Spanish, Chinese, Japanese, Portuguese & Finnish. The older manuals (2006) may still be used for languages that don't have an updated version, including Arabic, Dutch, German, Greek, Hindi, Italian, Khmer, Korean, Punjabi, Russian, Tagalog & Vietnamese.

LAACHA Workgroups

Referral Systems
Facilitators: Katheryn Howell & Annie Pham
khowell@picf.org, anpham@ph.lacounty.gov

Networking, Training & Capacity-building
Facilitator: Open

External Communications
Facilitators: Mei Kameda & Enisha Clark
mkameda@keiro.org, enisha.clark@mptf.com

Internal Communications
Facilitator: Nicole Kaplan
nicole.kaplan@mptf.com

Comments, Ideas, Contributions?
Please contact Summer Nagano,
snagano@ph.lacounty.gov

General Meeting Highlights *(cont'd from page 1)*

In terms of funding for EBPs, SBSS obtains some monies from the City of Los Angeles, plus also obtains other grants. He said, "It is like putting a jigsaw puzzle together to find and maintain funding for EBPs, but it's worth the effort." In addition, he says a "small but confident group of staff members" are operating the EBPs at SBSS.

During the Q&A session, the panelists offered these tips for agencies that would like to begin offering EBPs:

- Since staffing can be a challenge, consider training more than one person. Talk to other agencies that are offering EBPs. They may be willing to help with staffing.
- Don't get discouraged. Be persistent and continue to be passionate about offering EBPs.
- Go through the EBP program first, and then become a facilitator.
- Involve volunteers early so that they can be helpful to your agency.
- Gather stories and testimonies from people who complete the EBP classes, and obtain their permission to use their stories in your class recruitment materials.

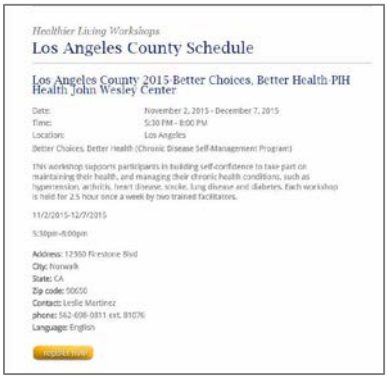
Workshop Referrals

Are you or anyone in your organization planning to lead an upcoming EBP workshop? If so, be sure to have it listed on the California Healthier Living website's Los Angeles page at www.cahealthierliving.org/locations/losangeles/.

Listing your workshops on this website provides free advertising for your classes, and includes your specific contact information for registration.

This website is managed by Partners in Care Foundation and funded by the California Department of Public Health and the California Department of Aging.

To add your workshop to the website, contact Natalie Zappella at (818) 837-3775, ext. 159. ◈


Healthier Living Workshops
Los Angeles County Schedule
Los Angeles County 2015 Better Choices, Better Health PIH Health John Wesley Center

Creating Community Linkages Assessment

Q 1. Has a doctor, nurse, or other health professional ever told you that you have a long term illness or health issue?

A. No - **Go to Q2.**

B. Yes - Ask client which chronic conditions (mark all that apply):

1. Heart disease - if yes, eligible for **CDSMP**
2. Asthma - if yes, eligible for **CDSMP**
3. Hypertension - if yes, eligible for **CDSMP**
4. Stroke - if yes, eligible for **CDSMP**
5. Cancer - if yes, eligible for **CDSMP**
6. Arthritis - if yes, eligible for **CDSMP** and/or **CPSMP**
7. COPD/Emphysema - if yes, eligible for **CDSMP**
8. Chronic pain - if yes, eligible for **CDSMP and CPSMP**
9. Depression - if yes, eligible for **CDSMP**
10. Diabetes - if yes, eligible for **DSMP** and **CDSMP**; **AND GO TO Q4**
11. Other (List) _____ - eligible for **CDSMP; AND GO TO Q3**

Q2: Do you take 5 or more medications?

A. No - Go to Q3

B. Yes - eligible for **CDSMP**

Q 3: Have you been told by a doctor that you are at risk for diabetes or have been diagnosed with pre-diabetes?

A. Yes - eligible for **Diabetes Prevention Program and GO TO Q4**

B. No - Conduct assessment below: Ask client….

1. (Only display for women)Are you a woman who has a baby weighing more than 9 pounds at birth
2. Do you have a parent with diabetes?
3. Do you have a brother or sister with diabetes?
4. Height: _____Weight:
5. (Only displayed if client <65 years) Do you get little or no physical activity in a typical day?
6. If client is between 45 and 64 years of age, system will automatically allocate 5 points. If outside of age range, then 0 points.

7. If client is 65 years of age or older, system will automatically allocate 9 points. If younger than 65 years, then 0 points.

If total score is ≥ 9 eligible for **Diabetes Prevention Program; AND GO TO Q4**

Q 4. How many hours per week are you physically active?

A. 2 or more hours per week - **GO TO Q5**

B. Less than 2 hours per week - eligible for **Walk With Ease** or **Arthritis Foundation Exercise Program** or **Tai Chi Program; AND GO TO Q5**

Q 5. Do you care for someone who has a long term illness or health issue ?

A. Yes What is the Health Condition?

If Dementia, eligible for **Savvy Caregivers**

If Other, eligible for **Powerful Tools for Caregivers**

B. No

If 65+ years go to Q6. If <65 years, END OF ASSESSMENT

Q 6. Falls Prevention Assessment: Have you…?

A. Have you fallen in the past year?

B. Do you sometimes feel unsteady when you are walking or standing?

C. Are you worried about falling?

Scoring: If client answers **Yes** to any above three questions, eligible for **A Matter of Balance** or **Stepping On**

Q 7. Do you have any concerns about your memory or do you wish to improve or maintain your memory?

A. Yes - eligible for **Memory Training program**

B. No -

END OF ASSESSMENT

Display of all eligible programs with one line descriptions. If eligible for >1 program ask, "Of these programs, which program would provide you the best value?" Mark the program(s) client is interested in. (See attached for the program names and summaries)

Take Charge of Your Health!

Breast Cancer & Mammograms

Facts about Breast Cancer

- Breast cancer is the most common cancer among women.
- All women are at risk for breast cancer even if they have no family history.
- As a woman gets older, her risk of breast cancer goes up.

When breast cancer is found and treated early, it is more likely to be curable.

Common Questions

What is a mammogram?

- A mammogram is an X-ray of the breast.
- The best way to find breast cancer is with regular mammograms.

How often should I get a mammogram?

- The standard recommendations are:
  - Ages 40-49: Talk to your doctor.
  - Ages 50-74: Every 2 years
  - Ages 75 and over: Talk to your doctor
- If you have questions about when to start and how often to get mammograms, talk to your doctor.

What else should I know?

- Be aware of how your breasts feel normally so you'll notice if they feel different than usual.
- If you feel a lump or swelling in your breast or underarm, see a doctor as soon as possible.

Mammogram Appointments

Where can I get a mammogram?

- If you have medical insurance/coverage, Medi-Cal, or Medicare, call your doctor.
- **If you have no medical insurance/coverage, call**
  Women's Health Hotline
  1-800-793-8090

Friendly operators from the Office of Women's Health can set up a **free** or **low-cost** appointment near you.

Operators speak English, Spanish, Chinese, Korean, Armenian, and Vietnamese.

Los Angeles County Department of Public Health - Office of Women's Health
3400 Aerojet Avenue, Third Floor • El Monte, CA 91731 • (626) 569-3850
www.publichealth.lacounty.gov/OWH

County of Los Angeles Public Health

10/8/15

Women's Health

begins with a

Conversation

1-800-793-8090

Women's Health Hotline

Do You Need...

- An appointment for breast or cervical cancer screening?
- Health coverage/insurance or Medi-Cal?
- A Heart Disease Risk Assessment (by phone)?

Information & referrals for health, mental health & social services

Family planning/Pregnancy • Doctor appointments • STDs • Dental
Vision • Immunization • Housing • Food

Call Us. We are here to help you!

MONDAY – FRIDAY, 8 AM – 6 PM

We speak English, Spanish, Chinese, Korean, Vietnamese, Armenian

County of Los Angeles
Public Health

La Salud de la Mujer

empieza con una

Conversación

1-800-793-8090

Línea Directa de Salud para la Mujer

Necesita...

- ¿Una cita para un examen de detección de cáncer de seno o cervical?
- ¿Cobertura de un plan de salud/seguro médico o Medi-Cal?
- ¿Una evaluación por teléfono de su riesgo de una enfermedad cardiaca?

Información y Referencias de Salud, Servicios Sociales y Salud Mental

Planificación familiar/embarazos • Citas médicas • Enfermedades de transmisión Sexual • Dentista • Visión • Inmunizaciones
Vivienda • Alimentos

¡Llámenos! Estamos aquí para ayudarle.

LUNES A VIERNES, 8 AM – 6 PM

Hablamos Inglés, Español, Chino, Coreano, Vietnamita y Armenio

Condado de Los Angeles
Salud Pública